STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING _____ B. WING _____	R-C 02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER ROAD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit [PSR] to the PSR completed on 12/21/10, to the Recertification and State Licensure Survey completed on 11/10/10. This visit included the PSR to the PSR completed on 12/21/10, to the Investigation of Complaint IN00081189 completed on 11/10/10. Complaint IN00081189 - corrected. Survey date: February 3, 2011 Facility number: 000250 Provider number: 155359 AIM number: 100289980 Survey team: Rick Blain, RN TC Sue Brooker, RD Christine Fodrea, RN Census bed type: SNF/NF: 49 Total: 49 Census payor type: Medicare: 5 Medicaid: 42 Other: 2 Total: 49 Sample: 8 Riverbend Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the PSR to the Recertification and State Licensure Survey and in regard to the PSR to the PSR to the	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING _____ B. WING _____	R-C 02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	**7519 WINCHESTER ROAD FORT WAYNE, IN 46819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Investigation of Complaint IN00081189. Quality review 2/06/11 by Suzanne Williams, RN	{F 000}		